

Case Number:	CM15-0187629		
Date Assigned:	09/29/2015	Date of Injury:	05/14/2013
Decision Date:	12/04/2015	UR Denial Date:	08/26/2015
Priority:	Standard	Application Received:	09/23/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 66-year-old female who sustained an industrial injury on 5/14/13. Injury was reported relative to continuous trauma. The 7/6/15 treating physician report cited grade 9/10 persistent right shoulder pain. Physical exam documented severe supraspinatus tenderness, moderate greater tuberosity and acromioclavicular (AC) joint tenderness, and mild biceps tendon tenderness. Right shoulder range of motion was limited with forward flexion and abduction 90 degrees. There was subacromial crepitus. There was 4/5 shoulder strength. AC joint compression and impingement tests were positive. Imaging demonstrated supraspinatus and infraspinatus tendinosis with partial thickness rotator cuff tear and AC joint degenerative joint disease. Conservative treatments included activity modification, physical therapy, and medications. Authorization was requested for arthroscopic right shoulder decompression, distal clavicle resection and labral or rotator cuff debridement and associated surgical services to include home continuous passive motion (CPM) device for rental 90 days, Surgi-Stim unit for rental 30 days, Coolcare cold therapy unit, and shoulder immobilizer with abduction pillow for purchase. The 8/26/15 utilization review non-certified the associated surgical requests for home CPM device for rental 90 days, Surgi-Stim unit for rental 30 days, Coolcare cold therapy unit, and shoulder immobilizer with abduction pillow for purchase as the associated surgery was not certified.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Associated surgical service: Home continuous passive motion device for rental 90 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (updated 08/06/2015), online version.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous passive motion (CPM).

Decision rationale: The California MTUS does not provide recommendations for continuous passive motion (CPM) following shoulder surgery. The Official Disability Guidelines state that CPM is recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Guidelines state that CPM is not recommended after rotator cuff shoulder surgery. Clinical exam findings are consistent with adhesive capsulitis. Although the use of CPM during the post-operative period for home use would be appropriate for this injured worker, there is no compelling reason to support the medical necessity of this request beyond the 4-week guideline recommendation. Therefore, this request is not medically necessary.

Associated surgical service: Surgi-Stim unit for rental 30 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The SurgiStim unit provides a combination of interferential current, neuromuscular electrical stimulation (NMES), and galvanic current. The California MTUS guidelines for transcutaneous electrotherapy do not recommend the use of NMES in the treatment of chronic pain. Galvanic stimulation is considered investigational for all indications. Guidelines suggest that interferential current is not recommended as an isolated intervention. Patient selection criteria is provided if interferential stimulation is to be used despite lack of guideline support and includes ineffective pain control due to diminished effectiveness of medications, intolerance of medications, history of substance abuse, post-operative pain limiting functional ability, and failure to respond to conservative measures. Guideline criteria have not been met. There is no indication that standard post-op pain management would be insufficient. There is no documentation that the patient was intolerant or unresponsive to pain medications during the pre-operative period. If one or more of the individual modalities provided by this multi-modality unit is not supported, then the unit as a whole is not supported. Therefore, this request is not medically necessary.

Associated surgical service: Coolcare cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (updated 08/06/2015) online version.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Continuous flow cryotherapy.

Decision rationale: The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery for up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request is not medically necessary.

Associated surgical service: Shoulder immobilizer with abduction pillow for purchase:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (updated 08/06/2015) online version.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling.

Decision rationale: The California MTUS are silent regarding post-op abduction pillow slings. The Official Disability Guidelines state that these slings are recommended as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. This patient has a partial rotator cuff tear and arthroscopic repair has been requested. Guidelines generally support a standard sling for post-operative use. There is no compelling reason to support the medical necessity of a specialized abduction sling over a standard sling. Therefore, this request is not medically necessary.